Outpatient Drug Free/Day Care Habilitiative (Rehabilitative)

☐ **Initial** ☐ **Updated**

TREATMENT PLAN

(For Use as Initial or Updated)

ASSIGNMENT OF A PRIMARY COUNSELOR (NAME):

CLIENT NAME:	CLIENT IDENTIFICATION #:	DSM CODE:

Review previous Treatment Plan & Progress Notes, if any. Carry forward all problems. Use original date on old problems. . Use Index Number for each problem/goal/ plan.

1 = Drug Use; 2 = Medical; 3 = Legal; 4 = Psychosocial; 5 = Educational; 6 = Employment/Vocational; 7 = Financial 8 = Discharge

	Date Identified .	Statement of Problems	Goals to be Reached Which Address Each Problem	Action Steps Taken by Provider and/or Client to Accomplish Identified Goals	Target Date	Date Target Met

Frequency of Counseling_____	Individual_____	(Circle) weekly or monthly	Group _____	(Circle) weekly or monthly

Primary Counselor Signature:	Signature Date:	Physician Signature:	Signature Date:
Counselor Signature:	Signature Date:	Client Signature:	Signature Date:

Disclaimer: The use of this form is not required by the State of California, Department of Alcohol and Drug Programs. This is a tool for Drug Medi-Cal providers, which meets the specific requirements to be documented under Title 22, California Code of Regulations, Section 51341.1(h)(2)(A). This form also includes requirements of the California Standards for Drug Treatment Programs (Revised September 1982); and Alcohol and/or Other Drug Program Certification Standards (March 15, 2004). Clinical and/or program information may be added to this form; however, we caution you to consider whether those additions would conflict with the basic requirements contained within this document.

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